reviews

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TV

My Foetus

Channel 4, 20 April at 11 05 pm

Rating: ★

Termination of pregnancy is a difficult issue with rights and wrongs, whatever your personal perspective. It is difficult for patients, it is difficult for healthcare professionals, and it is difficult for society. I work as an obstetrician in a city where one in three pregnancies is terminated. It is hard to rationalise an approach that promotes safe motherhood within an environment of high "wastage." Termination of pregnancy is a bitter fact of life for many people in the United Kingdom and it affects us all in one way or another. I am confused about termination and I am not alone. There is tremendous scope for mainstream medical journalism to contribute to an informed debate, to educate, or even to provoke and challenge the values of sexually active people in this country. And so I watched this Channel 4 documentary with interest.

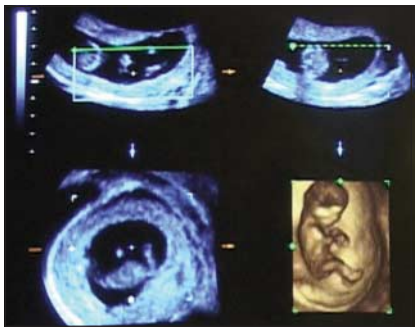
CHANNEL 4

Filmmaker Julia Black

Julia Black, a filmmaker, is in the third trimester of pregnancy and having experienced a previous termination decides to address the "abortion debate." She believes that a pervasive silence surrounds the physical reality of termination so that it has become easy to be pro-choice without challenging what that really means. The focus of her documentary was on the imagery of termination with graphic overblown images of aborted fetuses, heart warming shots of ultrasound scans at varying gestational ages, and filming of a day case termination procedure at four weeks gestation. These images were interspersed with frequent lingering close ups of the healthy growing abdomen of the narrator herself. What was perhaps shocking was that it wasn't very shocking at all. An approach that focused on fetal imagery was inevitably superficial and failed to address the issues that surround choice and decision making or the inevitable consequences of what may have seemed right at the time.

We heard the views of gynaecologists and of pro-life activists; we heard about women, but not from the women themselves. Apart from the filmmaker, who was hardly objective in the late stages of a wanted pregnancy, where were all the hidden women who have made this choice? What of their partners—must we perpetuate the concept of unwanted pregnancy being the exclusive responsibility of the woman? Many terminations of pregnancy in this country occur within stable relationships and are the result of shared decision-making. What of the mothers and fathers who counsel their daughters on unwanted pregnancy with the full knowledge of the challenges and joys of parenting? They were conspicuous by their absence. The complexities of termination cannot be addressed without exploring the perspectives of those most closely involved in the decision making. The silence of the protagonists made their plight all the more worrying.

The perception of termination of pregnancy as an "easy option" with the collusion of the medical profession and society in general was hinted at but simply not tested or explored. This was a missed opportunity. The only telling comment for me was that of the gynaecologist performing the suction termination of pregnancy under local anaesthetic. At the end of the procedure she said to the woman on the table, "How was that for you?" We didn't hear the answer. She moved into the next room and sifted through the products of conception for the film crew explaining that she wouldn't even look for limb buds until nine weeks. For some people termination of pregnancy is routine and even mundane or so it seemed. In fairness, we all protect ourselves by blunting difficult situations with routine behaviour and a degree of denial; however, it was an important warning shot.



CHANNEL 4

The focus on fetal imagery was superficial

Do graphic images help in understanding why termination happens or what we can do to prevent it or its consequences? Can we address this issue in the same way for a couple with a malformed fetus or lethal condition, for a mother who may die in pregnancy because of underlying medical disease, a woman struggling with psychiatric disease, the pregnant drug user, the victim of domestic violence, rape, or the many situations that lead a woman to a desperate decision? It is a tragedy that our technical sophistication in imagery has not been matched by preventive measures or by alternative choices for women and couples who are not ready for a pregnancy or the challenges it holds. We saw a gynaecologist replacing embryos as part of an assisted conception procedure who then described his willingness to perform late surgical terminations of pregnancy. What is wrong with our society that we cannot support women in making the decision to place a baby for adoption? Why does it not even deserve a mention?

Termination of pregnancy is a difficult and complex issue. Sadly I fear that we are no further on following this one dimensional approach to a multi-dimensional issue.

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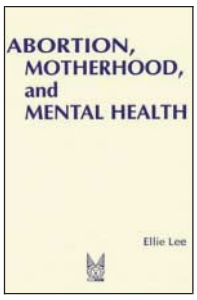
Competing interest: DJM is a non-practising Catholic.

Items reviewed are rated on a 4 star scale (4=excellent)

Abortion, Motherhood, and Mental Health: Medicalizing Reproduction in the United States and Great Britain

Ellie Lee



Aldine de Gruyter, $29.95/sFr48/€29.95, pp 293
ISBN 0 202 30681 X
www.degruyter.com/aldine

Rating: ★★★

By contrasting post-abortion syndrome with postnatal depression, Ellie Lee provides a fascinating and excellent interrogation of modern day abortion and motherhood within the United States and Britain. Both these countries have embraced what might be loosely called a therapeutic ethos. An increasing list of common occurrences—from bereavement and divorce to moving house and being criticised—is now liable to generate a psychiatric label such as post-traumatic stress, depression, or anxiety. Surprisingly, however, post-abortion syndrome has failed to take a place within this modern "syndrome society."

On both sides of the Atlantic, advocates of post-abortion syndrome have met considerable resistance from official psychiatric and psychological associations. Numerous studies are cited as failing to provide any evidence of widespread post-abortion syndrome and mental health professionals have made clear demands that transient feelings should not be confused with illness. All those concerned with women's health seem united in stating that the effects of abortion on women's minds should be set in context and not exaggerated.

This contrasts starkly with postnatal depression; for example, mental health professionals, politicians, and feminists routinely place the tragic case of the Texan mother Andrea Yates, who took the lives of her five children while experiencing extreme puerperal psychosis (*BMJ* 2002;324:634), on the same continuum as women suffering postnatal "baby blues." Demands for evidence and balance have prevented the runaway diagnosis of post-abortion syndrome, limited to less than 1% of women who have aborted, whereas postnatal depression is suggested to affect at least 10% and as many as 80% of mothers.

Part of the reason for this difference is that access to abortion had to be fought for and women who currently seek abortion are consequently viewed as active subjects with regard to their pregnancy. The unusual history and politicised nature of abortion limits the influence of a culture that would otherwise view women seeking termination as being at risk of psychological damage. As long as this remains the case, it will be difficult to present women as the victims of trauma following an abortion.

No such constraints prevail for childbirth, however, and Lee notes a "discernible element in cultural, academic, and professional representations of childbirth," perceiving the experience as "at least a psychological ordeal for women and very often a cause of mental illness." Having children is considered traumatic and depressing; abortion is seen as benign by comparison.

In Britain, the very provision of abortion is linked directly to the psychological risks of childbirth. Currently, two doctors must state that a woman's health is threatened for abortion to be recommended and risks to mental health are used to justify over 90% of British abortions. Almost every British abortion, therefore, emphasises the mental health danger of childbirth. While it may be accepted that women seeking abortion are strong, the justification for those abortions perversely emphasises the supposed diminished ability of women to cope with childbirth.

The flipside of rejecting post-abortion syndrome is to make more and more mothers the victims of postnatal depression. Such developments should be questioned, as Lee argues, and likely condemned as being against the interests of women in particular and society in general.

Stuart W G Derbyshire *assistant professor, University of Pittsburgh Medical Center, USA*
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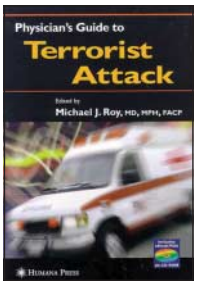
Physician's Guide to Terrorist Attack

Ed Michael Roy



Humana Press, $89.55, pp 420
ISBN 1 59259 663 0

Rating: ★★★

Paranoia is a wonderful stimulus for the imagination, and after reading this new guide you'll be surprised at the mind boggling ingenuity of 21st century terrorists. The very American interpretation of modern warfare suggests that there will be a move away from traditional theatres of war to more urban and civilian targets. This means that at any moment we can expect our local shopping centre to explode, the very water we drink to be contaminated while we receive anthrax through the post, and "rogue states" to drop dirty nuclear bombs on city centres. Mass transport systems are also highlighted, as attacks on these have the potential for widespread disruption and high numbers of casualties. The Supreme Truth sect's gassing of the Tokyo underground and the recent bombings of commuter trains in Madrid have, unfortunately, become textbook examples.

This well written guide provides in-depth, practical advice for dealing with a whole range of potential terrorist scenarios and, interestingly, for dealing with the psychological aftermath. Using numerous examples, it gives comprehensive and up to date information on the proper diagnostic and treatment methods for dealing with terrorist attacks.

When Russian special forces stormed a Moscow theatre being held siege by Chechens last year they used a noxious opiate gas that caused rebels and hostages alike to collapse, vomit, and asphyxiate. The government hindered its own health services by refusing to identify the agent used, compromising many lives. In Japan, medical services were slow to respond after the sarin gas attacks, and this cost lives. In contrast, after the attacks on the World Trade Center and the Pentagon in 2001 the emergency services went into overdrive, efficiently putting major incident plans into action. Triaging of survivors—although initially difficult and chaotic—was streamlined, helping to reduce the mortality of such a large attack. This guide outlines the typical initial response to an attack and describes well the disorientating nature of the disorder that results, as well as the problems for hospitals needing to receive mass casualties or even responding to anxious patients fearful of exposure to a biological agent.

Medical experts with a military background (think Dustin Hoffman in *Outbreak*) review possible infectious diseases and chemical agents that could be used in terrorist attacks. The book also deals with important issues of an "efficiently lethal" nature: casualties from blasts, nuclear and radiological weapons, guns, and mines. The possibilities for carnage are limitless, but this book provides an action plan for doctors at the front line of a terrorist attack response team and everyone working in an emergency department. It's scary reading but a good defence.

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PERSONAL VIEW

Screening must remain a free choice

Charity letters asking for donations are a fact of life. This morning, however, there was a charity letter asking not for my money, but merely my support. The "Ignorance Isn't Bliss" campaign—launched this week and run by the Prostate Research Campaign UK with support from AstraZeneca—wants me, as a general practitioner, to display posters, and disperse leaflets encouraging women to use the "carrot and stick" approach to "persuade your man to talk to his doctor about his prostate health." This campaign is different: it is for prostates, but for women. Sisters, we are being encouraged to "leave medical information leaflets lying around where he is likely to find them—ie, the bathroom, near the remote control or the car seat." Women are wanted for our nagging abilities—and if you can't do it face to face (by "tugging at his heartstrings—do it for me/us/the family, as it means such a lot"), we are to do it by stealth. We are encouraged to lie, deceive, pressurise, and whine till we get our own way ("Book a double appointment with the doctor for a check up for the both of you, and tell him he's going with you.")

I have no doubt that the people behind this campaign are sincere people who want to reduce deaths from prostate cancer. On that I fully support them. However, I can't support this campaign.

Why? If I were the general practitioner responsible for "checking up" a competent adult pressurised into coming to see me, I would feel rather troubled. Firstly, what check up? We offer few screening tests that are clearly effective and none that are entirely harmless. The Prostate Research Campaign's leaflet tells us that as men get older "regular check-ups . . . are even more necessary." To be fair, the accompanying letter from professors of oncology and urology makes clear the controversy surrounding prostatic specific antigen (PSA) testing, but the leaflet, intended for women to arm themselves with information before tackling the household male, does not. It merely states that one in three men with a high PSA will have cancer, and that "his chances are greatly improved by early diagnosis and early intervention."

This I object to. If one thing is clear, it is that PSA testing is highly contentious and unproven as an effective screening tool; and there is a good argument that the test should not be done at all unless as part of a trial—for example, the ProspecT trial. Until this study reports, PSA screening cannot be advocated for the population—and certainly not for an individual without circumspect consideration. While GPs are obliged to offer a PSA test, after counselling, the unfortunate conclusion I fear from reading the leaflet is that good men get PSA tests done, and good women make sure of it.

The idea that the only good citizen is one who has screening tests is, to me, abhorrent. I wonder what would happen if the situation was reversed. I would not enjoy being shepherded in to my local health centre by my husband for a cervical smear. No competent adult should be cajoled or manipulated into doing what someone else thinks is best for them. Adults are capable of making their own decisions about risk, but they need good, honest information to do that.

There is a danger to the culture of "awareness." While knowledge is power, it is only functional if harnessed to disperse and aid decision making properly. Otherwise, well meaning campaigns are in danger of worrying the well and failing to reach the very people who may be most likely to benefit. While superficially the idea of increased awareness of prostate disease seems intuitively correct, the idea that women should seize responsibility for men's health implies that men are incapable of making their own decisions or getting their own information. This could be seen as patronising and even emasculating.

> I would not enjoy being shepherded by my husband for a cervical smear

Are there not other ways that could better improve male health? For example, there is surely a need for further research into how best to get clear information on health directly to boys and men. Or how access to health services should work for symptomatic men—do we need to provide more of a "barber shop" walk in service rather than the current "salon" style, pre-booking arrangement that currently dominates in general practice?

Whatever other work needs to be done, meanwhile it should be made clear that engaging in screening is a free choice, which may or may not have benefits, and significant side effects. Over the last few years many unproven screening tests have become widely available. Besides the cost to the NHS the potential detrimental cost to the individual is lost somewhere in the feel-good, check-up, on-the-safe-side, do-the-right-thing vibe. It should not be. I agree with the Prostate Research Campaign that ignorance is not bliss. But ignorance of the implications of false positives, false negatives, potentially unnecessary invasive interventions, and the current lack of evidence to support PSA screening—that is not bliss either.

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Competing interest: MM has written articles for various newspapers and magazines, which have included features about health.

SOUNDINGS

Pedalling up the Amazon

I have been subscribing to a local fitness centre for years but have not lost any weight at all. Sometimes my wife suggests that I ought to go and at least look at the place. She says it is delightful, full of slim people of both genders.

That's the trouble. What I want to kick-start my personal struggle against cuddliness is a gymnasium where I don't stick out. I resemble the "before" part of the advertisements and I feel conspicuous. More muscle would be nice, certainly, but what I really need is nerve.

My opportunity came on our last cruise. Like most people these days we take a winter holiday but we are non-skiers. This year, South America was as far off-piste as we could get.

The routine history at booking, at least with this cruise company, is: "Are you a wheelchair user?" No. "Will you be bringing your own oxygen?" No. "Do you require syringes and needles?" Certainly not. By the time you put the phone down you feel years younger.

On board, the fitness centre was on deck 9 at the front—near the internet cafe. My wife radiated silent approval of my trips for'ard until, two days out from Recife, she caught me among the workaholics logging in to the office email.

Shortly afterwards I was in the gym, blending in with other first timers as Katie, the youthful instructor, explained which piece of apparatus trains what. She related well to wrinklies. She made jokes, avoided looking at our bodies, and knew about cardiopulmonary resuscitation. It was my kind of place, I decided.

Pedalling against resistance with a pulse rate of 120, I waited for the endorphin surge. Katie had said you had to break sweat.

The last time I was in a gym, back in 1964, it was all wallbars, ropes, and beams. Now I had a digital display of calories burned and a button to press if I needed to go downhill.

Time to pump some iron. Adjust the peg to reduce the weight. The last user must have been some kind of a freak. Outside, the banks of the Amazon slid past. Inside, I was doing 3.6 mph on the running track.

Feel the burn, man. Get some samba CDs for the Walkman and this just might change your life.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*